

obtained in the management of multiple and resistant anogenital warts by applying SADBE directly to the lesions with those obtained by applying it to remote unaffected areas.

From June to December 1999, nine patients, seven adults (mean age 32 years) and two children (mean age 10.5 years), were treated. Following sensitisation by topical application of 3% SADBE in acetone directly to the skin of the pubic region in adults and to the back of the hands in children, serial dilutions (0.0003% to 3%) were tested 2 weeks later on the same skin area in order to evaluate the minimal concentration capable of eliciting an eczematous reaction. Subsequently, the application of the compound was performed in the clinic by trained staff twice a week. SADBE application varied by age of patients and anatomical site of lesion. In children, SADBE was applied to the dorsal left hand; in adults it was directly applied to lesions located on skin, or to the pubic area when lesions were located on mucosae. If an eczematous reaction was not elicited after 1 week, an incrementally higher concentration was applied. If a strong reaction ensued, the treatment was discontinued for 3–6 days and an incrementally lower concentration was used at the following visit.

A total of eight patients completed the therapy, showing complete resolution after a mean of 16 weeks of treatment, with variable concentrations of SADBE ranging from 0.0003% to 0.3% (table 1). Local side effects (erythema, desquamation, cutaneous oedema, pruritus, burning, and pain) were generally mild and well tolerated. No relapses occurred during an 18 month follow up.

Clinical resolution and length of treatment in patients treated by applications to remote areas was comparable with those in which SADBE was applied directly to lesions. These results not only substantiate the efficacy and safety of topical SADBE in the treatment of multiple recurrent/recalcitrant anogenital warts, but also indicate a possible systemic effect of contact immunotherapy, suggesting that the mechanism of action of SADBE could be more than a non-specific inflammatory reaction or a local cell mediated process triggered by a non-wart antigenic immune stimulus.

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Accepted for publication 19 April 2002

Recreational drug use by GUM clinic attendees

Recreational drug use (RDU) is widespread in the United Kingdom.¹ Studies have suggested that RDU is associated with an increased risk of STI or blood borne virus (BBV) acquisition.^{2–6}

A search of Medline 1966–2000 found no studies looking at the prevalence of RDU in UK genitourinary medicine (GUM) clinics. Therefore this study aimed to estimate the prevalence of RDU by attendees of the Plymouth GUM clinic and to see if the diagnosis of an STI is more common in illicit drug users.

The local research ethics committee approved the study. New patients attending the clinic between August and November 2000 completed a questionnaire which listed a number of drugs and asked about frequency of consumption and injecting drug use. Respondents were asked for their clinic number so that test results could be compared to drug use.

The completion rate was 76% (259/339). The mean age of respondents was 26 years (range 15–54) and 58% were women.

Lifetime illicit RDU was reported by 64% (166/259, confidence interval (CI) 5.8) with 28% (72/259, CI 5.5) reporting use within the past month. Of 16–24 year olds, 66% (87/132, CI 8.1) reported lifetime use while 34% (45/132, CI 8.1) reported recent use. There was no significant difference in use between men and women (66% v 62%). Figure 1 shows the proportion of clinic attendees who reported taking each drug.

Two people, 0.77% (2/259, CI 0 to 1.87) of respondents, reported injecting drug use. Most people, 64% (165/259), supplied their clinic number, and 32% (52/165) were diagnosed with an STI. Men were more likely to be diagnosed as having an STI (OR 2.72, CI 1.40 to 5.28). The diagnosis of an STI was independent of units of alcohol drunk in the preceding month (OR 1.07, CI 0.78 to 1.46), and the use of illicit drugs whether in lifetime (OR 0.82, CI 0.43 to 1.60) or in the past month (OR 1.51, CI 0.71 to 3.20). Subjects who gave their number were less likely to take illicit drugs (OR 0.44, CI 0.25 to 0.77).

This survey has revealed a high prevalence of recreational drug use by attendees at a

GUM clinic. Comparing the data with the 2000 British Crime Survey (BCS) shows that the proportion of clinic 16–24 year olds who admitted to illicit drug use within the past month is greater than the same age group surveyed in the BCS (OR 2.32 CI 1.59 to 3.37). Likewise, lifetime use was more common (OR 1.86, CI 1.29 to 2.69).

There is a low prevalence of injecting drug use; this might be due to under-reporting. An alternative explanation is that this high risk group is not accessing the clinic. If this is the case it would support moves to set up an outreach clinic.

This study found that the diagnosis of an STI is independent of RDU. This might be because RDU is so common that it is no longer a useful discriminator; alternatively, a larger sample size might have found evidence of an association.

In conclusion, although RDU is common, injecting drug use appears to be rare in this group. The findings of this survey have implications for service provision.

Acknowledgement

I thank Steven Skov for his criticism of the manuscript.

Conflict of interest: none.

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Accepted for publication 23 April 2002

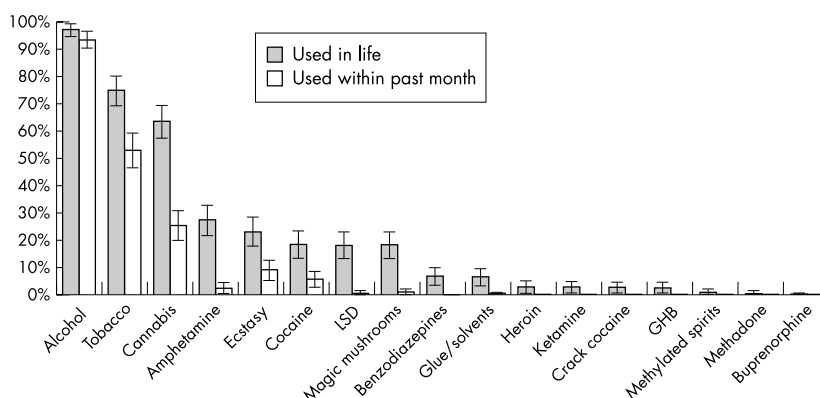


Figure 1 Proportion of respondents reporting use of each drug. Error bars show 95% confidence interval.